PROGRAM: (List all that apply)_____

MONROE COUNTY SOCIAL SERVICES
DISCLOSURE OF INFORMATION

CLIENT NAME: _____ Client Address: _____
Client Phone: (___)_____ _____

I. CONSENT FOR MONROE COUNTY TO OBTAIN INFORMATION.

I, the person named above, hereby consent to the release to the Monroe County Social Services Department, program(s) listed above, of any and all information concerning my physical condition, treatment rendered, medical and hospital records, and all social and financial information concerning me for the purpose of ascertaining qualification for services of the above-listed program.

Dated: _____ _____
(Client's Signature)

II. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the person named above, authorize the above–listed program office(s) to release to any third-party-payer any medical, psychiatric or psychological, substance abuse, contagious disease (including sexually transmitted diseases such as syphilis and HIV) and case management information, including information received by the Department from others for purposes of billing third parties, including state and federal agencies. I understand that this information may be transmitted electronically.

I further authorize the release of such medical information to _____(Fill in or put N/A).

Dated: _____ _____
(Client's Signature)

III. EXPIRATION OF CONSENT

I understand that the above granted authorizations shall expire only upon my written revocation.

Dated: _____ _____
(Client's Signature)

IV. RIGHTS OF CLIENT

I understand I have the rights to limit the authorization of disclosure to specific information and to specific persons, to revoke the authorization in writing, to inspect and copy protected health information used or disclosed and to be notified of each request if I so specify in writing, to refuse to sign the authorizations and that refusal to sign the authorizations or failure to provide information may make it difficult to arrange services for me.

Dated: _____ _____
(Client's Signature)